Practice Improvement Protocol 17

Arizona State Hospital: Effective Utilization and Collaboration

Developed by the
Arizona Department of Health Services
Division of Behavioral Health Services

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Issue:
As the Arizona State Hospital is a long-term inpatient psychiatric hospital that provides the most restrictive (i.e., longer term treatment), highest level of care available in the state, and is Arizona's only state operated psychiatric hospital, it is imperative that clinical data support the admission of any person as being medically necessary and that this level of care is the most appropriate and least restrictive alternative treatment option for the person. Additionally, to communicate the hope of recovery for each individual, collaboration with the patient, family, or legal representatives, and community providers to identify individual recovery supports that will lead toward community reintegration becomes a cornerstone of the admission and treatment process at Arizona State Hospital.

Purpose:
To establish protocols that facilitate collaborative decision-making between the Arizona State Hospital, Tribal/Regional Behavioral Health Authorities (T/RBHAs), and other referring agencies, the patient, family, and other legal representatives for admission, treatment planning, and discharge of patients from the Arizona State Hospital. This protocol replaces the use of collaborative agreements directly established between each T/RBHA and the Hospital.

Target Populations:
All T/RBHA enrolled adolescent and adult behavioral health recipients and any other persons who meet involuntary commitment criteria (T-36, T-13, T-14, and T-8, A.R.S. § 12-136 {Tribal Orders} and T-31 {Female Correctional Inmate Transfers}), and who may benefit from treatment at the Arizona State Hospital.

This practice improvement protocol applies to the following categories of patients who may be admitted to the Arizona State Hospital:

1. Civilly committed adult patients (T-36 and A.R.S. § 12-136 and A.R.S. § 31-226), regardless of whether or not they have an established legal guardian with mental health powers (T-14+).
2. Forensically committed adult patients (T-13) including patients who have been adjudicated as Guilty Except Insane (GEI) or Not Guilty by Reason of Insanity (NGRI).
3. Adolescents (ages 13-17) who are committed under civil (T-8 or T-36) or forensic (T-13) statutes, regardless of whether or not they have an established legal guardian with mental health powers (T-14+).

Definitions:
Mental Disorder means a substantial disorder of the person's emotional processes, thought, cognition, or memory (A.R.S. § 36-501(26)). Mental disorder is distinguished from:

a) Conditions that are primarily those of drug abuse, alcoholism, or mental retardation, unless, in addition to one or more of these conditions, the person has a mental disorder. Primary diagnoses of a Substance Abuse-Related Disorder or Mental Retardation are excluded from admission. Primary diagnosis refers to the chief disorder for which the person requires treatment. If the predominant

treatment required relates to active/ongoing substance abuse or mental retardation, admission is denied.

b) The declining mental abilities that directly accompany impending death. (Primary diagnoses of a Delirium and/or Late-Stage Dementia-Related Disorders are excluded from admission.)
c) Character and personality disorders characterized by lifelong and deeply ingrained antisocial behavior patters, including sexual behaviors that are abnormal and prohibited by statute unless the behavior results from a mental disorder. (Primary diagnosis of Antisocial Personality or Paraphilia-Related Disorders are excluded from admission.)

Danger to Others means that the judgment of a person who has a mental disorder is so impaired that he is unable to understand his need for treatment and as a result of his mental disorder, his continued behavior can reasonably be expected, on the basis of competent medical opinion, to result in serious physical harm.

Danger to Self means:

a) Behavior which, as a result of a mental disorder, constitutes a danger of inflicting serious physical harm upon oneself, including attempted suicide or the serious threat thereof, if the threat is such that, when considered in the light of its context and in light of the individual's previous acts, it is substantially supportive of an expectation that the threat will be carried out.
b) Behavior which, as a result of a mental disorder, will, without hospitalization, results in serious physical harm or serious illness to the person, except that this definition shall not include behavior which establishes only the condition of gravely disabled.

Gravely Disabled means a condition evidenced by behavior in which a person, as a result of a mental disorder, is likely to come to serious physical harm or serious illness because he is unable to provide for his basic physical needs.

Persistently or Acutely Disabled (PAD) means a severe mental disorder that meets all of the following criteria:

a) If not treated has a substantial probability of causing the person to suffer or continue to suffer severe and abnormal mental, emotional, or physical harm that significantly impairs judgment, reason, behavior, or capacity to recognize reality.
b) Substantially impairs the person's capacity to make an informed decision regarding treatment and this impairment causes the person to be incapable of understanding and expressing an understanding of the advantages and disadvantages of accepting treatment and understanding and expressing an understanding of the alternatives to the particular treatment offered after the advantages, disadvantages, and alternatives are explained to that person.
c) Has a reasonable prospect of being treatable by outpatient, inpatient, or combined inpatient and outpatient treatment.

Guilty Except Insane (GEI) (after 1996) means that at the time of the commission of the criminal act the person was afflicted with a mental disease or defect of such severity that the person did not know the criminal act was wrong. Mental disease or defect does not include disorders that result from acute voluntary intoxication or withdrawal from alcohol or drugs, character defects, psychosexual disorders, or impulse control disorders. (Persons designated GEI are placed under the authority of the Psychiatric Security Review Board (PSRB) for a term of commitment equivalent to their sentence had they been convicted and sent to prison.)

Not Guilty by Reason of Insanity (NGRI) (prior to 1996) means that at the time of commission of the criminal act the person was afflicted with a mental disease or defect of such severity that the person did not know the criminal act was wrong and is therefore not responsible for his criminal conduct. (Persons designated as NGRI remain under the authority of the original Court of commitment indefinitely.)

Incapacitated Person means any person who is impaired by reason of a mental illness, mental deficiency, mental disorder, physical illness or disability, chronic use of drugs, chronic intoxication, or other cause, except minority, to the extent that he lacks sufficient understanding or capacity to make or communicate responsible decisions concerning his person.

Title 14 Guardian means any person who has been appointed by a Court to have specific powers, rights, and duties with respect to matters involving the "incapacitated person."

Title 14 Guardian with Mental Health Powers (T-14+) means any person who has been appointed by a Court to have specific additional mental health powers with respect to matters involving the "incapacitated person" when the ward has been determined to be incapacitated due to a mental disorder.

Background:
In accordance with A.R.S. §§ 36-204, 36-205, and 36-206, the Deputy Director of the Division of Behavioral Health Services (DBHS) adopts rules for inpatient services at the Arizona State Hospital with the approval of the Director of Arizona Department Health Services (ADHS), which assure proper review of treatment and discharge plans, arrangements for aftercare placements, transfer of medical records, and assistance with medications. There is a Superintendent of the State Hospital who is appointed by the Deputy Director, with final approval of the Director, and reports to the Deputy Director. The Superintendent, with the approval of the Deputy Director, appoints a Chief Medical Officer of the State Hospital. The Chief Medical Officer is responsible for the clinical administration of the hospital (including admission, evaluation and treatment, and discharge of all patients) and reports to the Superintendent.

ADHS/DBHS is committed to providing high quality, effective, and individualized care in the community, and strives to furnish successful home and community-based services for all consumers in an effort to promote resiliency and facilitate recovery. However, when a more restrictive level of care is necessary, the State Hospital is available and committed to meet these specialized needs.

ADHS is committed to providing behavioral health services across the continuum of care for all enrolled behavioral health recipients. When less restrictive community treatment options have been attempted and determined to be unable to meet the needs of the person, or when it is determined that longer term Level I Behavioral Health Hospital level of care at the most restrictive/highest level of care is necessary and provides the most appropriate placement for the person to be treated, Arizona State Hospital is available to meet these specialized needs. The goal of all hospitalizations of persons at the Arizona State Hospital is to provide comprehensive evaluation, treatment, and rehabilitation services to assist each patient in his/her own recovery, and to achieve successful placement into a less restrictive community-based treatment option.

According to A.R.S. § 36-202, a state hospital is to be available for the "care and treatment of persons with mental disorders, and persons with other personality disorders or emotional conditions who will benefit from care and treatment." The Arizona State Hospital admits patients up to the limit of its funded bed capacity and thereafter establishes a waiting list of patients for further admission. Overall and sub-population bed capacities are established and maintained by authority of the Arizona State Legislature.

Procedures

Admissions (T/RBHA enrolled; Non-Forensic):

In order to ensure that individuals are treated in the least restrictive and most appropriate environment that can address their individual treatment and support needs, the criteria for clinically appropriate admissions to the Hospital are as follows:

For all non-forensic adolescents and adult patients (not under T-13):

a) The patient must be medically cleared (i.e., not require acute medical care beyond the scope of care at the State Hospital or hospitalization for medical care) prior to admission to the Arizona State Hospital.
b) The T/RBHA has made reasonable good-faith efforts to address the individual's target symptoms and behaviors in an inpatient setting(s) and/or other local behavioral health treatment programs.
c) For patients who are also enrolled with the Arizona Department of Economic Security/Division of Developmental Disabilities (DES/DDD), the DES/DDD Medical Director, or designee agrees with the T/RBHA's recommendation for admission.
d) The T/RBHA has completed Utilization Review of the potential admission referral and is recommending admission to the Arizona State Hospital as necessary and

appropriate, and as the least restrictive option available for the person given their clinical status.

e) When a community provider agency believes that a non-forensic adolescent or adult is a candidate to be transferred from another Level I Behavioral Health treatment facility for treatment at the State Hospital, the agency will contact the T/RBHA with which the person is enrolled to discuss the recommendation for admission to the State Hospital. The T/RBHA must be in agreement with the community provider agency that a referral for admission to the State Hospital is necessary and appropriate.

f) The T/RBHA shall contact the Admissions Office of the Arizona State Hospital to make the referral for admission. No patient is admitted to the State Hospital without the prior approval and acceptance by the Hospital's Chief Medical Officer per Arizona Administrative Code R9-21-507B.

g) For TBHA (Tribal RBHA only) enrolled behavioral health recipients, ADHS/DBHS must also be in agreement with the referring agency that admission to the Arizona State Hospital is necessary and appropriate, and ADHS/DBHS must prior authorize the person's admission.

h) The T/RBHA shall contact the Hospital's Admissions Office and forward a completed packet of information regarding the referral to the Admissions Office. The Hospital cannot accept any person for admission without copies of the necessary legal documents, including any Court Ordered Treatment (COT) orders or T-14+ guardianship documents. The T/RBHA should verify that the admission packet clearly identifies what symptoms or skill deficits are preventing the patient from participating in treatment in the community and what treatment objectives are to be addressed through treatment at the State Hospital.

i) The certification of need (CON; ADHS/DBHS Provider Manual Form 3.14.1) included in the packet of information should certify that proper treatment of the person's psychiatric condition requires services on an inpatient basis under the direction of a physician; that inpatient services can be reasonably expected to improve the person's condition or prevent further regression so that inpatient services will no longer be needed; and, that ambulatory care services available in the community will not meet the treatment needs of the person.

j) Once accepted for admission, the T/RBHA needs to generate a Letter of Authorization (LOA) or Intent to Pay. The LOA or Intent to Pay should be faxed to the Hospital's Patient Finance Department within 24 hours of admission. For patients between the ages of 21-64, the T/RBHA is responsible to notify the Hospital's Finance Office of any previous days utilized by the patient in an Institution for Mental Disease (IMD). For Title XIX/XXI patients between the ages of 21-64, the Hospital may not request payment for services delivered in excess of 30 days per admission and 60 days per calendar year. The Hospital Finance Office will notify the Arizona Health Care Cost Containment System (AHCCCS) Member Services of the patient's admission to the Hospital.

k) When all necessary documentation is received, Admission Office staff review the packet and complete a Patient Profile Summary that presents a clinical picture of the patient being referred and efforts which have been made by the T/RBHA to place the patient in a less restrictive alternative, including any unique obstacles

and/or barriers that must be addressed. The packet is then forwarded to the Chief Medical Officer for review and determination.

l) The Chief Medical Officer will review the information within two business days after receipt of the completed packet and determine whether the information supports admission, and that the Hospital can meet the patient's treatment and care needs. If the Chief Medical Officer is considering denial of admission based on the information submitted in the admission packet, the Chief Medical Officer will communicate to the T/RBHA Medical Director or designee this preliminary decision prior to issuing a written denial. This will allow the T/RBHA Medical Director or designee to review the submitted information again and to forward any additional information which may impact the decision of the Chief Medical Officer.

m) If the Chief Medical Officer determines that the patient is inappropriate for admission, the Chief Medical Officer will provide a written statement to the T/RBHA explaining why the patient is not being accepted for admission and the referring T/RBHA will be offered the opportunity to request reconsideration, by submitting additional information or by conferring with the Chief Medical Officer. The Admission Office will fax the statement to the referring T/RBHA. In addition, the State Hospital will issue a Notice of Action letter and appeal rights to the consumer being denied admission.

n) If the admission is approved, the Admission Office will fax the acceptance statement from the Chief Medical Officer to the referring T/RBHA.

o) A Court Order for transfer is not required by the State Hospital when the proposed patient is already under a Court Order for treatment with remaining inpatient days. However, in those jurisdictions in which a Court Order is required, the referring agency will present the above Statement to the Court and petition for the transfer of the patient to the Arizona State Hospital. If a Court Order for transfer is not required, the Admissions Office will set a date and time for admission. It is the responsibility of the referring agency to make the appropriate arrangements for transportation to the Hospital, and to provide the Admission Office with the Certificate of Need for the date of admission.

p) When the Hospital reaches its funded civil or adolescent capacity for either males or females, the Hospital shall establish a waiting list for admission. The wait list shall be based on the date of receipt of the court order. When a wait list is in effect, the Admissions Office may be contacted for information regarding status of the patient on the civil waiting list.

For adult patients under civil commitment (T-36):

a) The patient must have a primary diagnosis of Mental Disorder (other than Mental Retardation, Substance Abuse, Paraphilia-Related Disorder, or Antisocial Personality Disorder) as defined in A.R.S. § 36-501, which correlates with the symptoms and behaviors precipitating the request for admission, and be determined to meet DTO, DTS, GD, or PAD criteria as the result of the mental disorder.

b) The patient is expected to benefit from proposed treatment at the Arizona State Hospital (A.R.S. § 36-202).

c) The patient must have completed 25 days of mandatory community treatment in a local mental health treatment agency under T-36 Court Ordered Treatment (COT),

unless waived by the court per A.R.S. § 36-541 or, if PAD, waived by the Chief Medical Officer of the Arizona State Hospital.

d) The Arizona State Hospital must be the least restrictive alternative available for treatment of the person (A.R.S. § 36-501). No less restrictive long-term level of care is available elsewhere in the State of Arizona to meet the identified behavioral health needs of the patient.
e) The patient must not suffer more serious harm from proposed care and treatment at the Arizona State Hospital. (A.A.C. R9-21-507(B1)).
f) Hospitalization at the Arizona State Hospital must be the most appropriate level of care to meet the person's treatment needs and the person must be accepted by the Chief Medical Officer for transfer and admission (A.A.C. R9-21-507(B2)).

Non-T/RBHA Enrolled TXIX/XXI Admissions:

In the event that the prospective patient is not currently enrolled with the T/RBHA and the admission is determined medically necessary, the Hospital will complete a referral and CON at the time of admission or at the earliest point at which the medical necessity determination has been made. The referral, CON, and documentation supporting the medically necessary admission are faxed to the T/RBHA's Utilization Management Department. If the patient is a resident in the geographic service area served by the T/RBHA, the patient should be enrolled by the T/RBHA effective the date of initial notification to the T/RBHA by the Hospital. Within 24 hours of receipt, the T/RBHA must conduct a face-to-face visit, assessment, and disposition per ADHS/DBHS Provider Manual 3.2, Appointment Standards and Timeliness of Service**.** The T/RBHA's Utilization Department should make a determination whether payment will be authorized and should notify the Hospital Utilization Manager.

The T/RBHA should fax a Letter of Authorization (LOA) or Intent to Pay to the Hospital's Finance Office within 24 hours of receipt of the CON. In the event that the T/RBHA does not agree the hospitalization is medically necessary, the Hospital must determine whether to request reconsideration and initiate the Dispute Resolution Process if needed, or immediately discharge the patient to an appropriate placement as determined by the T/RBHA.

For patients who become Title XIX/XXI eligible subsequent to admission, the Hospital is responsible for completing all required CONs.

Treatment and Discharge Planning for All Patients:

a) The Hospital will begin treatment and discharge planning immediately upon admission**.** For adults, this is accomplished by utilizing the Adult Clinical Team model. For adolescents, this is accomplished by utilizing the Child and Family Team model. All treatment is patient-centered and is provided in accordance with DBHS-established five principles of person-centered treatment for seriously mentally ill adult consumers and in accordance with the Arizona 12 Principles for adolescent consumers.

a. Consideration of comprehensive information regarding previous treatment approaches and outcomes and recommendations/input from the T/RBHA and other outpatient community treatment providers is vital.
b. Representative(s) from the outpatient treatment team are expected to participate in treatment planning throughout the admission in order to facilitate enhanced coordination of care.
c. Treatment goals and recommended assessment/treatment interventions shall be carefully developed and coordinated with the outpatient providers (including the T/RBHA, ALTCS Health Plan, DDD, or other provider(s)), the consumer or legal guardian, or family members, and/or significant others as authorized by the patient whenever possible.
d. The first staffing should address specifically what symptoms or skill deficits are preventing the patient from participating in treatment in the community and the specific goals/objectives of treatment at the Arizona State Hospital. This information should be used to establish the treatment plan.
e. The first staffing should also address the discharge plan for reintegration into the community. The patient's specific needs for treatment and placement in the community, including potential barriers to discharge and successful return to the community, should be identified and discussed.

b) The Hospital Treatment Team will fax all treatment plans to the T/RBHA and other involved providers and to the legally responsible party for the patient. The T/RBHA and other involved providers should indicate review of and agreement/disagreement with the treatment plan on the document. Any disagreements should be discussed as soon as possible and resolved. (The Dispute Resolution process is outlined later in the protocol.)

c) Treatment plans are reviewed/revised collaboratively with the Adult Clinical Team (ACT) or Child and Family Team (CFT) at least monthly. The patient's assigned Hospital social worker will attempt to coordinate monthly meetings (staffings) based on availability of the T/RBHA and other involved providers or persons approved by the patient to participate. The Hospital and T/RBHA shall take appropriate steps to obtain the participation of all members of the patient's Adult Clinical Team or Child and Family Team, and attempts to coordinate team meetings should be documented.

d) Any noted difficulties in collaboration with the outpatient provider treatment teams will be brought to the attention of the T/RBHA to be addressed. The T/RBHA Hospital Liaison shall monitor the participation of the outpatient team and assist when necessary.

e) Through the Adult Clinical Team or the Child and Family Team process, the Hospital will actively address the identified symptoms and behaviors which led to the admission, and link them to the community rehabilitation and recovery goals whenever possible. The Hospital will actively seek to engage the patient and all involved parties to establish understandable, realistic, and practical treatment goals and interventions to be implemented, which are based upon the patient's individualized treatment needs. The Hospital will encourage and assist the patient to continue to address these goals upon discharge through development of

discharge plans that are similarly established. Consumer self-determination is encouraged and supported.

While in the Hospital and depending upon the patient's individualized treatment needs, a comprehensive array of evaluation and treatment services are available and will be utilized as appropriate and as directed by the patient's treatment plan and as ordered by the patient's treating psychiatrist. Such evaluation and treatment services include but are not limited to:

- Comprehensive psychiatric, medical, nursing, social work, psychological, rehabilitation, and spiritual assessments.
- Support services including laboratory, radiological, physical therapy, occupational therapy and rehabilitative services, spiritual counseling, and general supportive activities to assist patient in their activities of daily living.
- A variety of individual psychotherapy and counseling services, including Cognitive-Behavioral Therapy, Dialectical Behavioral Therapy, Behavioral Therapy, and general supportive counseling, etc.
- Unit milieu management with daily community meetings and wrap-up meetings for daily goal setting and assessment of goal accomplishment
- Patient privilege system and use of the Adult Civil Facility's "Rehabilitation Mall" concept and design to promote patient responsibility, autonomy, and to practice self-care and socialization skills in a community-like environment.
- A variety of group therapies and group activities provided by licensed professional and other staff covering such issues as:
- Illness Management and Recovery
- Substance Abuse and Co-Occurring Disorders treatment
- Peer Support
- Crisis Management and Wellness/Recovery Action Planning (WRAP)
- Therapeutic Work Program
- Numerous other rehabilitation, recreational, and psycho-educational therapies, activities, and services.
- Adult Learning Programs and school for adolescents
- Other population specific groups for adolescents

T/RBHAs are entitled to conduct auditing and monitoring activities to evaluate the services being delivered by the Hospital to ensure that the services provided reasonably meet the needs of the patient and that appropriate records are being maintained. Reasonable advance notice to the Hospital and hours of visitation are expected.

Recertification of Need (Non-Forensic):

The Hospital's Utilization Manager is responsible for the Recertification process for all Title XIX/XXI Eligible Persons and is the contact for the Hospital for all T/RBHA continued stay reviews.

a) The Utilization Manager will ensure performance standards and compliance with timeliness by tracking and monitoring all Title XIX/XXI patients from the time of

admission until such time that the patient no longer requires inpatient level of care or the patient is no longer Title XIX/XXI eligible.

b) The Utilization Manager will complete a Recertification of Need (RON) every thirty (30) days for each Title XIX/XXI eligible patient under the age of 21 or over the age of 65 until such time as it is determined that continued stay is no longer medically necessary.

c) Adult Title XIX/XXI patients ages 21- 64 are eligible for 30 inpatient days per hospitalization or 60 inpatient days per year and, therefore, may not require recertification for continued stay following an initial 30 day authorization.

d) The Utilization Manager will work directly with the patient's attending physician to complete the RON form. The RON will be faxed to the RBHA within 30 days following the previously authorized time period.

e) If required by the T/RBHA, the Utilization Manager will provide by fax to the T/RBHA Utilization Review staff additional information/documentation needed for review to determine continued stay.

f) All T/RBHA decisions with regard to the approval or denial for continued stay will be rendered prior to the expiration date of the previous authorization and upon receipt of the RON for those patients under the age of 21 or age 65 and older. T/RBHA authorization decisions are based on review of chart documentation supporting the stay and application of the DBHS Level I Continued Stay criteria. If continued stay is approved, the T/RBHA shall fax a LOA/Intent to Pay to the Hospital Patient Finance Department within 24 hours or the next business day. Denials will be issued upon completion of the denial process described in the DBHS Provider Manual Section 3.14, Securing Services and Prior Authorization.

Discharge:

For all non-forensic adolescents and adults, and adolescents and adults under T-13 GEI or NGRI commitment who are ready for discharge, the patient is considered to be "discharge ready" when the following criteria are met:

a) The identified symptoms and behaviors that precipitated the admission, psychiatric, and/or medical problems subsequent to admission, and/or other problems preventing discharge have been addressed and no longer present barriers to discharge from or placement into a less restrictive community-based treatment setting.

b) The patient has achieved all treatment goals required for discharge as stated on the patient's Hospital treatment plan.

c) The patient presents no imminent danger to self or others based on her/his overall psychiatric/medical condition. Some patients, however, may continue to exhibit occasional problematic behaviors, such as individuals with developmental disabilities or Borderline Personality Disorder. These behaviors must be considered on a case-by-case basis and do not necessarily prohibit the person from being placed on the discharge ready list.

d) The recommended lower level of care is likely to maintain the person's present level of clinical stability.

e) All legal requirements have been met.

f) When the T/RBHA and other involved providers and the Hospital treatment team for the patient agree that the above criteria are met, the patient (or party legally responsible for the patient, if applicable) will be presented with the discharge plan and offered the opportunity to comment. The patient (or party legally responsible for the patient, if applicable) will be provided a Notice of Action letter and appeal information should they wish to dispute the discharge plan.

g) When the T/RBHA and other involved providers, the Hospital treatment team and the legally responsible party for the patient agree that the above criteria are met, the patient will be placed on the Discharge Ready List. If the clinical status of the patient changes while on the Discharge Ready List, such that successful discharge becomes unlikely, the patient shall be removed from the Discharge Ready List until such time as all parties again agree that the patient is discharge ready.

h) Once a determination is made to place a patient on the Discharge Ready List, the T/RBHA shall immediately take steps necessary in order to place the patient into a community-based treatment setting as soon as possible. The T/RBHA has up to thirty (30) days to transition the patient out of the Hospital. The Hospital Chief Medical Officer may allow extensions to the timeframe for discharge based upon individual case situations.

i) The Discharge Ready List is maintained by the Hospital, and the List is forwarded to the T/RBHA and all identified recipients on a monthly basis by the 10th day of each month. Recipients have an opportunity to review the list and must notify the Hospital's Director of Social Work and Clinical Services of any corrections by the 20th day of each month, after which time the list is considered final. If the List is revised, a new/revised Discharge Ready List is distributed to all identified recipients. The date on the Discharge Ready List, indicating when the patient was determined to be ready for discharge by all involved parties, is the date when the 30-day timeframe begins.

j) When the patient has not been discharged within 30 days and an extension has not been granted, a quality of care concern will be initiated by DBHS. The T/RBHA, in collaboration with the State Hospital, shall submit a performance improvement plan outlining steps to accelerate the discharge and how barriers to discharge will be tracked and addressed. Updates to the performance improvement plan will be due to the DBHS Office of Quality Management every 30 days until discharge is complete. This process will allow DBHS to gather data and to better identify network gaps and other barriers to prompt discharge to a lower level of care. However, if the T/RBHA does not submit performance improvement plans or demonstrate reasonable, ongoing efforts to transition a patient out of the Hospital, DBHS may proceed to a Notice to Cure or sanction, as is done with other performance improvement initiatives.

k) For forensic adolescents or adults, after the inpatient and outpatient treatment teams agree the patient is ready for discharge, the patient must then receive a Conditional Release order from the Psychiatric Security Review Board (PSRB) for GEI patients, or from the Superior Court of commitment for NGRI patients.

Dispute Resolution Process:

Any disagreements between the T/RBHA and the Hospital concerning (1) admissions, (2) treatment plans/treatment/services provided, (3) placement on the discharge ready list or the 30-days allowable for discharge should be resolved in a collaborative manner and at the lowest possible level. The following Dispute Resolution Process should be followed in this order using the attached Dispute Resolution Form (Attachment A):

- T/RBHA Medical Director or designee contacts Hospital CMO within 1 working day
  - Reconsideration decision completed within 2 working days
- If continued disagreement, the T/RBHA CEO and T/RBHA Medical Director or designee contact the Hospital CEO and CMO within 1 working day for reconsideration
  - Reconsideration decision completed within 2 working days
- If continued disagreement, either party may notify the ADHS/DBHS Medical Director or designee within 1 working day for reconsideration
  - The DBHS Medical Director or designee will review all pertinent written and/or verbal information provided by the T/RBHA
  - DBHS will render a final determination within 3 working days
  - Written decision issued to both parties

ATTACHMENT A

DISPUTE RESOLUTION PROCESS

Patient Name_____DOB:_____

Unit (if applicable)_____Treating Physician (if applicable)_____

T/RBHA_____

Summary of Disagreement: □ Admission □ Treatment □ Discharge

Step 1: T/RBHA Medical Director & Hospital CMO

Hospital CMO_____RBHA Medical Director_____

Date Called _____

Outcome:_____

Resolved: Yes____ No_____(If No, continue to next step.)

Step 2: T/RBHA Medical Director + CEO & Hospital CMO + CEO

Hospital CMO/CEO_____

RBHA Medical Director/CEO_____

Date Called _____

Outcome:_____

Resolved: Yes____ No_____(If No, continue to next step.)

Step 3:Final Determination by DBHS

DBHS Med. Dir._____

Date Called:_____ □ Written info sent □ Verbal info shared

Outcome:_____